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Notice of Independent Review Decision

September 9, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Bilateral L4-L5 and L5-S1 facet joint injection with IV sedation with CPT codes 64493, 64494, 77003 and 99144.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Partially Overturned (Agree in part/Disagree in part)

Medical documentation partially supports the medical necessity of the health care services in dispute. The ODG supports facet blocks or medial branch blocks for this patient with obvious tenderness over those joints, and this meets diagnostic criteria in the medical literature. There is no information regarding the need for IV sedation during the block therefore this portion is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work-related injury on xx/xx/xx. The patient was stopping a very large box to not fall and was stretching to catch it as well as using his bodyweight to push it back into the truck. While doing so, he sustained injury from twisting and bending.

xxxx: On xxxx, magnetic resonance imaging (MRI) of the lumbar noted: 1) In patient with left-sided pain, there was muscle injury. There was deep psoas muscle partial tearing, with small amount of hemorrhage however, no evidence of organized hematoma. There also was some bilateral paraspinous muscle edema. There was no evidence of any fracture however, compression fracture or pedicle fracture. 2) There was a 5 mm right posterior lateral protrusion with severe right neural foraminal narrowing at L2-L3. This was contralateral to the side of the patient's reported pain. 3) There was bilateral neural foraminal narrowing at L3-L4 and also at L4-L5, due to disc bulges and facet arthropathy. 4) There was some intra-spinous ligament edema of the lumbar spine. There was no evidence of nuchal ligament tear nor any avulsion fracture of the spinous processes. 5) would be happy to discuss these findings with the referring clinician at your convenience. The study was performed for the indication of back pain and left radiculopathy. There was no history of prior back surgery.

On xxxx, evaluated the patient for complaints of acute low back pain since a work-related injury. He also complained of decreased

range of motion (ROM) and numbness. The pain was in the bilaterally low back and lumbosacral area. It radiated to the thigh. The symptoms were constant and occurred daily. It was exacerbated by standing and direct pressure. It was relieved by rest and activity modifications. His history was remarkable for hypertension, hyperlipidemia and anxiety/depression. He was utilizing bupropion, carisoprodol, Norco, losartan potassium, omeprazole, prednisone and simvastatin. Examination of the lumbar spine revealed decreased ROM with pain on flexion and extension. There was tenderness over lumbar vertebra. reviewed the MRI findings and diagnosed him with lumbar spine sprain/strain. The patient was kept off work for one more week and was referred to start modalities.

On xxxx, suspected the patient might have a pedicle fracture and this might be his pain generator. The patient was recommended getting a bone scan. He was also recommended injections if no better after physical therapy, rest and medications.

On xxxxx, a three phase bone scan revealed no suspicious abnormality seen within the lumbar spine.

On xxxx, noted the patient had four sessions of therapy and was about 10% better. The results of the bone scan were discussed. The patient was recommended to complete the remaining therapy and requested a right-sided L2-L3 and L3-L4 test.

On xxxxx, noted the patient was approved six sessions of physical therapy and was feeling better. He was able to walk without the walker and was down to taking half Norco. He was able to discontinue the back brace mostly due to heat rash. The patient denied injection. referred him for pain management.

On xxxxx, evaluated the patient for low back pain and left leg pain. recommended functional capacity examination, ESI and continued physical therapy. Hydrocodone and Flexeril were prescribed.

xxxx: On xxxx, evaluated the patient for ongoing issues. The patient reported that he felt better, but still could not walk more than one mile without pain. He got exhausted with activity more than one hour. He had decreased lumbar range of motion in all planes at 25% with pain. Bending to right was painful at 50% of normal. refilled Ultracet and Daypro and recommended follow-up after functional capacity evaluation (FCE). Tramadol was prescribed.

On xxxxx, the patient underwent FCE that revealed him to be working in the medium physical demand level (PDL) which was equivalent to his job requirement.

On xxxxx, noted that the patient had started working, but gets exhausted by end of the day. He reported being hurt while doing a lot of activities at work. Tramadol helped. The FCE had showed some limitations in walking and climbing stairs from low back and left psoas injury. The patient was recommended continuing full time work. Flexeril and Daypro was refilled. Therapy was continued.

On xxxxx, reviewed the FCE result recommended continuing ongoing care.

On xxxxx, noted the patient's leg pain was better and he was working full time. His work had reduced his work load to 50%. He felt he was doing well and that PT was helping. He felt a lot stronger. recommended continuing work full time and stressed on continuing PT stretches. Tramadol was refilled.

On xxxxx, noted the patient's his left leg pain was better, however; he still felt twitches of the left anterior thigh muscle. It was noted that he was going to work full-time and he was able to perform all his duties although he felt weaker in the left leg. He was also having low back pain and he could not stand or walk for more than 5-10 minutes without having a lot of discomfort in the low back area. The patient noted that PT had helped him a lot as well and he felt stronger. He was taking Daypro. Examination of the lumbar spine was flexion non-painful, extension painful at 50%, rotation on the right was non-painful, rotation on the left was non-painful and lateral bending to the right was non-painful, lateral bending to the left was non-painful. The diagnoses were lumbosacral spondylosis without myelopathy, low back pain and lumbosacral neuritis or radiculitis unspecified. recommended bilateral L4-L5 and L5-S1 facet blocks, refill tramadol and Ultracet.

Per utilization review dated xxxxx, the request for bilateral L4-L5 and L5-S1 facet joint injection with IV sedation with CPT codes 64493, 64494, 77003 and 99144 was denied with the following rationale: *"The treatment plan included a bilateral L4-L5 and L5-S1 facet blocks, refill tramadol and follow-up after the injection and Ultracet. Per medical documentation dated July 23, 2015, it was noted that the patient was recommended a bilateral L4-L5 and L5-S1 facet joint injection. Per case notes it was noted that the patient had completed physical therapy, an MRI, 3 phase bone scan and it was noted that a caudal epidural steroid injection was denied. This request is not supported within the current Official Disability Guidelines Low Back Chapter regarding lumbar facet joint injection as well as the National Institutes of Health regarding IV sedation. In this case, the submitted documentation did not seem to adhere to guideline recommendations for facet joint pain, signs, and symptoms. The documentation did not indicate tenderness to the facets*

at L4-L5 and L5-S1. There did not appear to be findings of a radiculopathy. It was noted that there had been previous conservative treatment, however; facet joint pain, signs and symptoms have not been able to be verified. Additionally, there is no indication of why the need for sedation that has been submitted. Therefore, medical necessity of this request has not been established."

Per reconsideration review dated xxxxx, the appeal for bilateral L4-L5 and L5-S1 facet joint injection with IV sedation with CPT codes 64493, 64494, 77003 and 99144 was denied with the following rationale: *"The Official Disability Guidelines Low Back chapter, Facet joint diagnostic blocks (injections) and Facet joint medial branch blocks (therapeutic injections) indicate facet joint injection treatments should not be performed on claimants with findings of radicular pain of which exists in the treatment notes with reports of radiculitis, lumbar region. Also, I have no specifics regarding failure of a comprehensive conservative approach to treatment including 4 to 6 weeks of formalized therapy exercise program and NSAIDs prior to the request. There is also no indication of why the sedation is required. Medical necessity has not been established for bilateral L4-L5 and L5-S1 facet joint injection with IV sedation."*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The ODG supports facet blocks or medial branch blocks for this patient with obvious tenderness over those joints, and this meets diagnostic criteria in the medical literature. There is no information regarding the need for IV sedation during the block therefore this portion is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Facet joint intra-articular injections (therapeutic blocks)	Under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti , 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial. The therapeutic facet joint injections described here are injections of a steroid (combined with an anesthetic agent) into the facet joint under fluoroscopic guidance to provide temporary pain relief. (Dreyfuss, 2003) (Nelemans-Cochrane, 2000) (Carette, 1991) (Nelemans, 2001) (Slipman, 2003) (van Tulder, 2006) (Colorado, 2001) (ICSI, 2004) (Bogduk, 2005) (Resnick, 2005) (Airaksinen, 2006) An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. (Staal-*Cochrane*, 2009) *Systematic reviews endorsing therapeutic intra-articular facet blocks:* *Pain Physician, 2005:* In 2005 there were two positive systematic reviews published in *Pain Physician* that stated that the evidence was moderate for short-term and limited for long-term improvement using this intervention. (Boswell, 2005) (Boswell, 2005) These results were based, in part, on five observational studies. These non-controlled studies were confounded by variables such as lack of confirmation of diagnosis by dual blocks and recording of subjective pain relief, or with measures that fell under verbal rating and/or pain relief labels (measures that have been reported to

have problems with validity). (Edwards, 2005)
Pain Physician, 2007: Pain Physician again published a systematic review on this subject in 2007 and added one additional randomized trial comparing intra-articular injections with sodium hyaluronate to blocks with triamcinolone acetonide. The diagnosis of facet osteoarthritis was made radiographically. (Fuchs, 2005) Two randomized trials were not included, in part, as they failed to include controlled diagnostic blocks. These latter articles were negative toward the use of therapeutic facet blocks. (Lilius, 1989) (Marks, 1992) An observational non-controlled study that had positive results was included that made the diagnosis of lumbar facet syndrome based on clinical assessment of "pseudoradicular" lumbar pain, including evidence of an increase of pain in the morning and with excessive stress and exercise (no diagnostic blocks were performed). (Schulte, 2006) With the inclusion of these two articles the conclusion was changed so that the evidence for lumbar intra-articular injections was "moderate" for both short-and long-term improvement of low back pain. (Boswell2, 2007)
Complications: These included suppression of the hypothalamic-pituitary-adrenal axis for up to 4 weeks due to steroids with resultant elevated glucose levels for less than a week. (Ward, 2002) There have been rare cases of infection (septic arthritis, epidural abscess and meningitis). (Cohen, 2007) Complications from needle placement include dural puncture, spinal cord trauma, intraartierial and intravenous injection, spinal anesthesia, neural trauma, pneumothorax, and hematoma formation. (Boswell2, 2007)
Single photon emission computed tomography: (bone scintigraphy, SPECT scan): Not recommended although recent research is promising. This technique is recommended based on the ability of radionuclide bone scintigraphy to detect areas of increased function, depicting synovial areas of inflammation as well as degenerative changes. Thirteen of 15 patients had a > 1 standard deviation pain score improvement at 1 month versus 7 of 32 patients with a negative or no scan. The benefit of the injection lasted for approximately 3 months and did not persist to 6 months. (Pneumaticos2, 2006) See also Facet joint diagnostic blocks (injections); Facet joint pain, signs & symptoms; Facet joint radiofrequency neurotomy; Facet joint medial branch blocks (therapeutic injections); & Segmental rigidity (diagnosis). Also see Neck Chapter and Pain Chapter.

Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows:
1. No more than one therapeutic intra-articular block is recommended.
2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.
3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive).
4. No more than 2 joint levels may be blocked at any one time.
5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy.